Claim Form for Reimbursement

CHILD AND ADULT CARE FOOD PROGRAM

(See reverse side for instructions)

Institution: _____

ID Number: | | | | | | | For the Month of _____ 20 _____

For example: 1 2 3 4 5 A

Claims are due on or before the *10th* of each month. *Claims not received within 60 days of the claim month will not be paid* without USDA approval for a one-time exception. [REF: 7 CFR 226.10(e)]

Center Information:	**Current Month Enrollment:**	**Total number of CACFP meals served to enrolled children:**
____ Licensed Capacity	____ Free	_____ Breakfast
____ Number of Facilities	____ Reduced	_____ Lunch
____ Total Monthly Attendance	____ Paid	_____ Supper
____ Average Daily Attendance (total monthly attendance divided by number of days meals were served)	____ Total Enrolled	_____ Snack / Supplement
____ Number of Days CACFP Meals Served		

For Profit Centers Only

Proprietary Certification: For profit centers may not claim reimbursement for meals served to children in any month in which less than 25 percent of the children in care (enrolled or licensed capacity) were eligible for free or reduced price meals or were title XX beneficiaries. Children who only received at-risk afterschool meals must not be included in this percentage. [REF: 7 CFR 226.17(b)(4)] This institution certifies that at least 25% of the children in care (enrolled or licensed capacity, **whichever is less)** are classified as eligible for Free or Reduced price meals and meet eligibility requirements for this reporting month.

# of Free & Reduced Children: _____ Total Enrollment:_____ Licensed Capacity:_____ _____%

Authorized Signature _____

I certify that to the best of my knowledge and belief, this claim is true and correct, records are available to support it, it is in accordance with an existing agreement and applicable licensing requirements, and payment has not been received. I understand that this information is being given in receipt of federal funds and that deliberate misrepresentation of the information may subject me to prosecution under applicable state or federal laws.

Authorized Signature _____ Date _____

Title _____ Phone _____

Child and Adult Care Food Program
PO Box 202925
Helena, MT 59620-2925
Fax: 406-444-2547

Toll Free: 888-307-9333

Retain a copy for your files

CLAIM INSTRUCTIONS

TOTAL MONTHLY ATTENDANCE

Record the total number of participants in attendance daily. This should include every participant who attended during the day.

Each month, add together the attendance totals from each day. This is the total monthly attendance.

AVERAGE DAILY ATTENDANCE

(Round this number up to the nearest whole number)

$$\text{Average Daily Attendance} = \frac{\text{Total Monthly Attendance}}{\text{Number of Days the Center Operated}}$$

FR/P CERTIFICATION

1. Add Free and Reduced participants;
2. Compare the enrollment and licensed capacity, selecting the lesser number; then,
3. Divide F/R Participants by the lesser of enrollment or licensed capacity to determine if your center has met the 25% minimum and are eligible to submit a claim. The answer should be .25 or more.
4. **Example #1**:

Of F/R Children: 7
Total Enrollment: 36
Licensed Capacity: 30 ← Capacity is less than Enrollment.

```
   .233
30) 7.0
  - 60
    100
   - 90
     10
```

.233

Move the decimal two places to the right to convert to a percentage.

23.3% is less than 25%; this center **may not** claim.

5. **Example #2:**

Of F/R Children: 12
Total Enrollment: 46
Licensed Capacity: 35 ← Capacity is less than Enrollment.

```
   .342
35) 12.0
  - 105
    150
  - 140
    100
     -70
```

.342

Move the decimal two places to the right to convert to a percentage.

34.2% is more than 25%; this center **may** claim.

This claim form is available on the CACFP website at www.bestbeginnings.mt.gov